S. HRG. 103-575, PT. 2

ROUNDTABLE DISCUSSION ON THE ECONOMICS OF HEALTH CARE

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

PART 2

JUNE 30, 1994

Printed for the use of the Joint Economic Committee

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CONTENTS

WITNESSES AND STATEMENTS FOR THE RECORD

THURSDAY, JUNE 30, 1994

SUBMISSIONS FOR THE RECORD

ROUNDTABLE DISCUSSION ON THE ECONOMICS OF HEALTH CARE

THURSDAY, JUNE 30, 1994

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in room 2200, Rayburn House Office Building, the Honorable Lee H. Hamilton (Member of the Committee) presiding.

Present: Representative Hamilton and Senator Bennett.

Also present: Patricia Ruggles, George Foy, Steve Baldwin, Morgan Reynolds, Michelle Davis, Ken Nelson and Caleb Marshall, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE HAMILTON, MEMBER

REPRESENTATIVE HAMILTON. The Joint Economic Committee will come to order.

Today is another in a series of roundtable conversations that the Joint Economic Committee is holding with prominent economists to discuss economic policy. Today's topic, the economics of health care, is certainly one of the most important economic policy issues of the 1990s. We are pleased to have as our guest today Dr. Uwe Reinhardt, James Madison Professor of Political Economy at the Woodrow Wilson School, Princeton University.

Over the years, Dr. Reinhardt has made important contributions on the economics of health care. Dr. Reinhardt wrote *Physician Productivity and the Demand for Manpower in 1975*, and he undertook a study of West Germany's health-care system for the Pepper Commission in 1990. He has published numerous articles on health care in leading journals, and has also served on the U.S. Physician Payment Review Commission since it was established by the Congress in 1986.

Dr. Reinhardt, we are very pleased to have you. We look forward to a good discussion with you.

I understand you were very cooperative last night. We kept changing the schedule on you because of the schedule here. This has been a fairly hectic week for us in the Congress.

I am reasonably sure I won't fall asleep in this meeting, but I am working on very few hours of sleep for the entire week.

Let's go ahead. Do you want to begin with an opening statement, or go right to questions?

STATEMENT OF UWE E. REINHARDT, JAMES MADISON PROFESSOR OF POLITICAL ECONOMY, WOODROW WILSON SCHOOL, PRINCETON UNIVERSITY

DR. REINHARDT. I might make a brief statement.

First of all, I express my pleasure to be here. I did want to mention that Dr. Ruggles' father actually taught me and made me a health economist. I was going to be something altogether different and he persuaded me to pursue this field, and his daughter apparently as well.

I see health reform having mainly two goals: One is to provide economic and medical security to every American family. We call that universal coverage, but it really means that when people are ill they have access to the care they need, and in addition that their household doesn't go broke.

We pretend it has to do only with getting care, but it has to do with an image of a society in which a family whose member is stricken with, say, cancer doesn't get the double whammy of also going broke. This is a luxury every other family in every other nation has, but Americans don't have that. That is one goal, universal coverage.

The other is cost control, and those are in some ways separate goals. I have a chart that I often use to explain the two facets. One is the cash intake phase and the other the cash output phase. In the middle, stands some insurance pot.

People say health reform is difficult. It is politically difficult. Technically, it is quite simple. There are only three ways you can take money from households into the insurance pots, and there are only two ways that you can pay it out. Health reform; picking one or a mixture of ways to pay in and to pay out. The traditional method is that households bought their own health insurance, and that advocated by many particularly conservative spokesmen.

However, only 11 percent of the American people buy their own health insurance. Virtually everyone who says people should be individually responsible for their own insurance has actually their own insurance bought by their employer or given to them. That is a bit of an irony.

I know of absolutely no spokesman who proposes individual responsibility, who is in fact individually responsible for his or her own insurance.

On the way out, we face either fee-for-service, which is piece-rate compensation, or capitation by which we actually mean we pay a private regulator a lump sum at the beginning of the year and we tell that regulator you must give the insured all the health care they need, and you can beat up on the doctors and hospitals any way you wish, and keep the change. That is called "managed competition." And those are the only two options that we have.

I think as things shape up, we may or may not get the reform on the intake side, which really means recycling some net $40 billion from the upper third of the income distribution to the lower third. If you wish to achieve universal coverage, that is what that would ultimately mean.

I am not sure if there is the political will to do that. Technically, it is a small amount of money given that we are a $6 trillion economy that spends $1 trillion on health care; $40 billion is not an insurmountable amount of money but politically it may be insurmountable.

The income distribution of the United States, in 1990, they chose the distribution breaks at $35,000; half American households have less, half have more, but some 17 percent have an income of $15,000 or less.

I make my students memorize this. I put it on the exam because many students think the upper tier is the bottom tier given the way our students live. In fact, many Americans couldn't afford even a community-rated health insurance premium if it were made available to them.

So insurance reform *per se*, which means to detach insurance premiums from the health status of a household and not excluding preexisting illnesses, insurance reform of that nature is helpful, but it will not really make available to the lower 17, 20 percent of the income distribution the security we wish to give them.

If we want to help them, we must take money from people like me and somehow funnel it to them. If we are not willing to do it, there will be no universal insurance.

[The prepared statement of Mr. Reinhardt starts on p. 29 of the Submissions for the Record:]

REPRESENTATIVE HAMILTON. We often hear that we have a health-care crisis and then other people say we don't have a health-care crisis. What do you think, do we have a crisis or not?

DR. REINHARDT. The way I explain this on the speaking circuit is that it depends on the software in your soul. You look at certain data that are out there, which are indisputable, and then whether you call it a crisis or not depends basically on your value system. Forty million Americans have no insurance.

REPRESENTATIVE HAMILTON. That figure is going up?

DR. REINHARDT. Yes, and most are hard-working stiffs and their dependents. One-third of them are children. There are people, for example, Fred Barnes wrote in the *American Spectator*: "Where is there a health-care crisis?"

There are others, myself included, who would consider that a crisis, that many children don't have insurance and possibly don't have the kind of care——

REPRESENTATIVE HAMILTON. How many of the people who don't have health-care insurance make a choice not to have it?

DR. REINHARDT. Probably about a third could afford it. It would strain them a little, but they could afford it if it were compulsory.

REPRESENTATIVE HAMILTON. We will jump around quite a bit.

Senator Bennett, come in, glad to have you.

I want to go first to the question of health-care costs and get an idea, what is driving health-care costs up? The things that I have heard usually are: Technology, the demographics, getting older; is that correct and what would you add to the list? What is really driving health-care costs? We have had this inexorable increase in health-care costs over the past few years; what is driving it up?

DR. REINHARDT. Demographics is not.

REPRESENTATIVE HAMILTON. Even though we are getting older?

DR. REINHARDT. My son, who also is a Yaley, wrote a paper drawing on the literature that exists and showed that if nothing had changed except the aging of the population, only a very small percentage of the growth in health-care spending could be explained by that. I think it was 1 percent. I would have to look at his paper. But it was quite small.

It is a surprising conclusion. You take the age distribution, say, in 1980, and look at it in 1990, and say supposing in every age gender group people would have gotten the same per capita utilization throughout the 1980s that they got in 1980, how much more would we have spent in 1990, and it was a trivial amount more. That is one data point.

The other is that Germany today has an age distribution that we will reach only in the year 2020, I believe, and yet they spend less than 10 percent of their GNP on health care and we are at 14 percent.

What drives, technology drives, no question. The new marvels that come out, very expensive, often help very few patients drive.

A third driver is that the demand side of American health care really has so far had no ability to resist any price that they were charged, and that is how you can explain that our hospitals have a 61 percent occupancy ratio, 40 percent of the beds empty. We have four times as many mammography machines as we need.

The *Wall Street Journal* had an article on gamma knives, two hospitals in Miami have them, when one would be more than enough. The private insurance side is so splintered that no individual insurer has the market power to resist whatever price is charged.

REPRESENTATIVE HAMILTON. Is technology the single largest factor driving health-care cost?

DR. REINHARDT. Economists think it is.

REPRESENTATIVE HAMILTON. Let's go back to demographics. Ordinarily, we think that the largest health-care expenditures come in the final year of life. We are constantly pushing up the age of longevity. Why doesn't that increase your costs? I don't understand that.

DR. REINHARDT. I didn't quite believe my son's paper either, but I think when you look at it, you begin with a distribution of health spending, per capita, by age, and you do find that 85-year-olds, on average, are $10,000 a year and younger people less than a $1,000. So

you say, as we slide into that older age group, we must be spending more.

The demographic change is very, very gradual, so we are sliding into that higher age group at such a slow rate that year-to-year or even decade-to-decade increases are not driven by that.

REPRESENTATIVE HAMILTON. On the technology side, if you put limits on increases in costs, you are talking here about cost-containment, but if you put limits on these increases in costs, does that mean we are going to have less innovation in technology?

DR. REINHARDT. I don't think it means that necessarily, and this is one of those wishy-washy answers. The system we have now has been such that almost any "beep beep" machine could somehow find a customer, whether it did something or not. If you put some brakes on health spending, I think it will focus the mind of the producers of new technology to focus strictly on technology that is breakthrough, and not me, too.

REPRESENTATIVE HAMILTON. And what works?

DR. REINHARDT. What works and what has clinical efficacy, but also makes some economic sense. You might have a machine that does, on average, benefit 1 percent of the cases, but the costs are too enormous to justify it, but now all of that gets used.

REPRESENTATIVE HAMILTON. The fact that we are putting more and more of our GNP or GDP into health care, and so on, is that good or bad?

DR. REINHARDT. One might say that you have to worry what does it displaces. If it displaces the education of our young, if it displaces safety in the street, then I think it is a bad trade off. If it displaced firecrackers and balloons, I would say personally that it is a tolerable trade off. And we really don't know what it displaces. But given that 42 percent of health spending is through the public sector that is also largely responsible for education, I have a strong suspicion that eventually education will be the trade off.

REPRESENTATIVE HAMILTON. Forty-two percent of all health-care expenditure is by government?

DR. REINHARDT. Yes.

REPRESENTATIVE HAMILTON. Well, that is what, Medicare, Medicaid?

DR. REINHARDT. Medicare, Medicaid, CHAMPUS, the VA and the public health service. It is actually now 44 percent and rising. More and more chronically ill people are spewed out by the private insurer and dumped into the lap of government.

REPRESENTATIVE HAMILTON. Let me ask you, one of the things hospital administrators talk to you about all the time is this business of the Federal Government reimbursing for less than full cost, and boy, they really make that point, as I am sure you very well know. Is that accurate or not?

DR. REINHARDT. I think it is inaccurate. There is an exchange of letters that is just going through the *Wall Street Journal.* It started with an

opening salvo by Carl Schramm, who used to be head of the Health Insurance of America, but also a professor of economics, who argued that government pays only 88 cents on the dollar and therefore the private sector had to make up the difference.

My letter to the *Wall Street Journal* argued that that would be believable were it not for the fact that hospitals are 40 percent empty; they are only 60 percent occupied. So I asked my friend Carl, how is it then that you pay not only for the shortfall, you pay for all these empty beds and the profit margin on top. Name me another industry that has that much excess capacity that is profitable.

Hotels are not, office buildings are not, airlines are not; only the hospital industry remains profitable, running at a 60 percent occupancy ratio. The Columbia ACA system runs at less than 50 percent occupancy, is highly profitable, and if government doesn't pay for it, I ask who are the strange creatures who do pay for it. It is the private insurance companies of America that are perpetuated and financing this capacity.

REPRESENTATIVE HAMILTON. So the system we have now, where you have hospitals with 60 percent occupancies, is grossly inefficient?

DR. REINHARDT. It is grossly inefficient and that inefficiency, I argue, is sustained by the private insurance sector. They are paying for it and they are assuring it.

The most graphic example is mammography. The National Cancer Institute had a carefully researched article that showed at current user rates, we have four times the mammography machines in this country that we need.

I serve on the Physician Payment Review Commission, and we said, what should we recommend to the Congress for reimbursement; should we recommend that the U.S. taxpayer pay for that excess capacity? And we said no. We should recommend to Congress to pay a rate that would amortize a fully used mammography machine with a profit margin, and that rate came to $55, five years ago. That is what Congress did.

The private sector pays $120. The extra they pay is enough to pay for unused mammography machines. The damage is uninsured working women who want mammography, they have to pay $120. So, by having too many machines, we actually ration these women out of mammography.

REPRESENTATIVE HAMILTON. Why do you have too many machines?

DR. REINHARDT. Everyone wants to have it and the private insurance industry shovels the money out in such abundance that even if I have a machine that is used only one-quarter of the time, I can make money off it.

I invited Carl to my freshman class at Princeton to explain to 300 bright Americans why does the insurance industry do that, and I hope he accepts my invitation.

REPRESENTATIVE HAMILTON. One of the things that is impressing me more and more as I talk to people is the number of decisions now being

made in the labor force based on health care. It has really become a major factor in whether or not people accept jobs or don't transfer, or whatever. Health-care costs are driving more and more labor market decisions, I think.

DR. REINHARDT. Yes.

REPRESENTATIVE HAMILTON. I believe that is the case.

And at the same time, you have this phenomenon of stagnation in wages over a long, long period of time. What is the impact of the increase in health-care costs on wages?

DR. REINHARDT. Well, economists believe that in the long run those fringe benefits are taken out of the paycheck of the take-home pay of the workers. If you look at the data, you will find that take-home pay has increased much less rapidly than total compensation, and health care has displaced cash take-home pay and other benefits such as pensions.

REPRESENTATIVE HAMILTON. So I can say to the worker then, the reason they are not seeing, in all likelihood, an increase in their wages and their take-home pay is because their health-care costs are going up?

DR. REINHARDT. Yes. You would have almost all economists behind you on that one.

SENATOR BENNETT. Not employers.

DR. REINHARDT. You are right, Senator. They don't believe that.

SENATOR BENNETT. I was an employer until I got into this crazy business, so my perspective on what you are saying is very different. I would be delighted to come to Princeton and talk to your 300 students about what life is like in the real world.

DR. REINHARDT. Okay.

SENATOR BENNETT. I have been taking notes. I have to challenge a lot of the things you are saying because it does not coincide with my experience. Any "beep beep" machine can find a customer.

I have been involved in trying to sell a "beep beep" machine that demonstrably has significant medical benefits. I discovered the medical community to be the most conservative, the least entrepreneurial of any market I have ever tried to crack. They turned it down again and again because it was not invented here.

We finally had to give up. We sold it to Beck and Dickinson, who was able to put a million dollar marketing effort behind it, and they finally got it into the marketplace.

I think you are a little glib when you make that comment about technology. Let me take you through a hospital. I raised the same issue you have raised. I said, you guys have a MRI machine and you use it 25 percent of the time—pick a low number. Why do you do that?

I am a businessman; I understand about markets. The market clearly is not there for that machine if it is only used 25 percent of the time. They said, we have the machine because the market demands it. I said

this is double-talk, the market is not demanding it. And we yelled back and forth across the table.

I didn't yell that much because I was running for office and needed to make a good impression on them.

Finally, it dawned on me that when I say "market," as a businessman, I mean customers who buy things, the end users. When they say "market," they mean insurance companies.

I said, can't you get together with the other hospitals around town and decide that you will have only one? He said, if we did that, we would get no referrals. The insurance companies demand that we be a full service facility.

It is not the insurance companies pushing money out that does it; this hospital is on the verge of bankruptcy. They would love to refer all their MRI patients to the hospital across town and get out from under those costs.

So I come here convinced that the solution to that problem is doing something about the antitrust laws so that hospitals can talk to each other in intelligent ways.

We have an experience in Utah where we have one of the finest children's hospitals in the world. It is right next door to the University of Utah Medical School, a fine teaching research hospital, one of the 10 best in the country. We have spent as a state some $10 million of the University of Utah's budget.

Do you know how much effort it is for the University of Utah to raise $10 million? They spent $10 million in legal fees because some lawyer discovered that it violated the antitrust laws for the University of Utah to send their kids to primary care and blame the insurance companies for the breakdown of the antitrust laws, which is something that we in Congress can fix, which will bring four times the capacity of mammographies, and it will get to the point where the people with mammography machines can talk to each other and refer customers, and that will go away. It is not a matter of the structural problem of the insurance system.

I ought to pause for breath and let you comment.

DR. REINHARDT. There is no question that the antitrust laws often do stand in the way of efficient functions. It is a two-edged sword. If you didn't have antitrust laws, you might get the kind of collusion that would drive up prices and create monopolies, but with any law you can go too far, and there is a general sense among economists that the entire issue of antitrust laws needs to be revisited.

Usually, the private market gets around antitrust laws through mergers and consolidations. That is one way to get around it. And antitrust has not been that vigorous in challenging consolidations that hospitals are doing. That eliminates some of the excess capacity.

But when you said the insurance industry isn't funneling the money out, but they insist that every hospital is full service, to my mind, that is

part of the flaw. Why then do you need that many hospitals, each half empty?

SENATOR BENNETT. I agree with you, the problem is the hospitals have been half empty. You talk about Columbia HCA. I had the head of that hospital in my office yesterday afternoon talking about an issue that is very sensitive in Salt Lake City. I don't want to breach any confidence because there hasn't been a press announcement, but we have overcapacity in Salt Lake City, and if they come into the market, they will immediately close the hospital that they are looking to acquire.

As he went through the history of that company, which he described as highly profitable, they have become highly profitable by buying and closing hospitals.

DR. REINHARDT. That is why I call them "bounty hunters." We have concluded that the only way we come to grips with this capacity is to richly reward bounty hunters, and I think it is an honorable activity, to take down this excess capacity and become billionaires in the process.

SENATOR BENNETT. I much prefer it being done by private activity than government fiat.

DR. REINHARDT. There are areas, of course, where they would not venture, and that is inner cities, where we then have to make sure that capacity is there for those citizens. Otherwise, I am totally on their side.

SENATOR BENNETT. You talk about 44 percent of the system being currently under government control and you list the items. I don't have any academically compiled data on this, but the overwhelming assumption on the part of everybody that I have talked to is that the 44 percent that is under government control is the area of least quality and lowest service.

Anecdotal evidence—I had a general in my office talking about veterans benefits and he said, "Senator you are not going to cut our veterans benefits, are you?" And so on.

We got on the subject of VA hospitals, and this general told me that he had just had a heart bypass and that he had gone to LDS Hospital in Salt Lake rather than the VA hospital, because it was his life he was playing with and he was not going to trust himself to the kinds of doctors that you have under government control; this isn't a reassuring kind of attitude when you think of putting 100 percent under government control.

DR. REINHARDT. If I may break down the 42 percent, the government is only the insurer. The delivery system is private. The Medicare and Medicaid, which is delivered in regular community hospitals, is the same quality care. We know this from studies that everyone else gets.

I don't think anyone would argue that America's elderly get low-quality care.

SENATOR BENNETT. That is true, but I know specific instances of a number of physicians who will not provide care for Medicare or Medicaid patients. They say the hassle is not worth it.

The paperwork and bureaucracy is so overwhelming that if you walk into one of their offices, they will not provide care.

REPRESENTATIVE HAMILTON. Is that a growing number of physicians?

DR. REINHARDT. The Physician Payment Review Commission keeps track of that and it is quite small.

REPRESENTATIVE HAMILTON. Ten percent or less?

DR. REINHARDT. It does occur, but we are in charge of monitoring access and so far we have not discovered any major problem.

REPRESENTATIVE HAMILTON. I hear that all the time, too. I have never really known how many physicians——

DR. REINHARDT. The Commission issues a report every June and the latest one, monitoring, is just out.

REPRESENTATIVE HAMILTON. A lot of physicians threaten.

SENATOR BENNETT. Maybe, you and I get that because the constituents——

DR. REINHARDT. We actually survey, and so does the Secretary. She also publishes the monitoring of access reports and we monitor hers, so there is a fair amount of hands-on monitoring in that, but there are anecdotes of course, and physicians threaten more frequently than they do it, which I would too. It is a good posture.

SENATOR BENNETT. You responded to the Chairman's, "What does it displace," with an answer that implied that you believe this whole circumstance is a sum zero game; that is, a dollar spent on health care can't be spent on anything else.

Rather than, as I believe, it is a true limitless kind of circumstance, and that if the dollar is not spent on health care, that doesn't mean education is necessarily deprived. That just means the dollar isn't spent. Respond to that.

DR. REINHARDT. Actually, I could submit a paper that I wrote on this very issue because it is very, very tricky. In fact, I belong to the school that has said health-care spending *per se* is not an issue; the percent of GNP going to health care is not really an issue, if that is what the people prefer.

SENATOR BENNETT. I am delighted to have you say that because the implication of your statement to the Chairman as I came in was to the contrary.

DR. REINHARDT. Only the piece thrust into it is not a zero sum game. At the state level, for instance, like in New Jersey, health care is growing apace, but the budget, we have a new governor committed to cutting taxes. Then you are artificially creating a zero sum game, and I was talking strictly about the 44 percent that is coming under that.

In the private sector, I think whatever it displaces ... in fact, until recently we spent more on tobacco. We certainly spend more on tobacco and alcohol than on all pharmaceutical products research.

SENATOR BENNETT. Let's talk about overcapacity for a minute. I have to go to an anecdote because I am not in the business of conducting

studies. My wife has had 2 knee operations, the first one 10 years ago, and she spent 10 days in the hospital. The second one on the other knee, arthroscoptic surgery; I drove her in in the morning and took her home at noon.

Somebody raised a lot of money and went to a lot of effort to build Good Samaritan Hospital in Los Angeles on the assumption that it would be 10 years for knee surgery for everybody who comes along, and then somebody invents a technology where it is literally done in a doctor's office. And the overcapacity circumstance, I don't think, once again, you can say that it is because the insurance companies are shoveling out money to keep those hospitals alive. I think the overcapacity is a function of the technology that has come along and rendered what used to be viewed as a great benevolent community benefit suddenly obsolete, because nobody needs to stay in hospitals anymore.

I am not sure of these figures, but I have been told and would like your response; that the average length of stay in a German hospital is much longer than in the United States, and sometimes can be as much as twice as long as in the United States. There is a suspicion that the German system keeps these beds full simply to demonstrate that somehow they are utilizing them properly. In other words, the desire to make the system as designed in the 1960s, or whenever it was put together, still works in the 1990s; they are preventing the kind of quality care that would say, sorry guys, all those hospitals you built in the 1950s, 1960s, suddenly we don't need anymore and your system isn't flexible enough to recognize that. Would you comment on that?

DR. REINHARDT. There is something to what you say. If you look at per capita utilization of hospital beds, it plummeted in the 1980s, which was in part a creator of some of the excess capacity, an overhang. Yet, in spite of that, new capacity was still brought on line and you read stories like the gamma knife or the Kalamazoo helicopter war, where one hospital bought a helicopter and competitively the other had to have it, and so on. It is this competitive game that exacerbates it.

If we had not had the new technology, our hospitals probably would be 75 percent occupied. On average, for the same thing, Germans stay twice as long in the bed than we do.

SENATOR BENNETT. Isn't that bad medicine?

DR. REINHARDT. Not necessarily. That would depend on how that works out for them. In many instances, I think we might discharge too soon in our country for the comfort of the patients. In our case, and I don't like to use anecdotes, but we had our second baby in Boston and my wife was, I thought and she thought, absolutely not ready for discharge. We pleaded for one extra day. I thought it was too soon, that it would have been better to stay.

REPRESENTATIVE HAMILTON. We hear a lot of complaints from constituents who think they are kicked out of the hospital too soon.

DR. REINHARDT. I think, in general, the Senator is right; too long a stay, hospitals are dangerous places. There is some happy medium. I think the Germans have too long; I think we push them out too soon.

SENATOR BENNETT. I don't mean to be deliberately argumentative with you, but I am convinced that, based on my study of this thing, the German system is on the verge, if indeed has not passed over the verge, and is in the process of coming unraveled. It is a wonderful system designed for a decade or two ago.

Our system clearly has serious, serious flaws. I would be the first to admit that. I argue with Republican colleagues who say everything is fine and all you need do is fine-tune around the changes. Everything is not fine and we need structural change. But I am very disturbed at suggestions that I hear coming out of some supporters of this Administration that say the German system is the one we should emulate, that is the one we should go in the direction of.

I think it is anti-technology; I think it is anti-quality in terms of the future. But there are some aspects of it, the idea that the individual owns his own policy, it is not owned by the employer, I applaud 100 percent. I think tying this to the employer is structurally the single most damaging thing we do in our present system.

But I get very distressed at suggestions that we ought to be moving in the European general direction, generally, and to the German system, particularly. You see, Senator, the problem, when people say the German system, it has many different facets. Some of them, for example, the way they collect the money, is actually quite clever.

You could call it an individual mandate, but it is convenient to collect it at the nexus of the payroll, so you take "X" percent of every individual, you never tie anything to the size of the firm, which I think is a horrible approach. That one is good.

I think the idea of an all-payer system is ultimately what people in America seem to be screaming for, because I hear two messages and people don't want to put them together. I hear on the one hand, the government isn't paying its fair share of hospital bills, but if you want the government to pay its fair share, basically that means government and private payers should sit on one side of the table, hospitals on the other, and you figure out a fair rate that every one pays. That is the all-payer system; that is what Germany uses.

On the other hand, Germany now has used a very unseemly budgeting system, and it won't hold. It was a temporary measure to take them to 1995. The idea is that they budget every sector—so much for drugs, so much for hospital, so much for doctors. That freezes technology.

They have a commission to study how to unlock the budget because the legislation goes only to 1995. I am going there to explain that managed competition is something they should at least look at. So I think the system is not unraveling, but is in the throes of a major change.

SENATOR BENNETT. One last comment. Speaking theoretically now—I don't want to be pinned down by a potential opponent in the primary

with what I am about to say—I could be enticed by the single-payer concept if we could tie to it absolutely, irrevocably requiring a constitutional amendment to change the notion that applies to catastrophic only.

I believe that one of the major, major problems that we have in health care is that we now have in the mind of every American that health care isn't any good unless it provides first-dollar coverage. I have lived, anecdotal, under that system.

I used to work for Howard Hughes, and Howard Hughes provided first-dollar coverage for anything. My kids teeth, no problem. Orthodontia, no problem. I could have sent him the vet bills for the dog and they would have paid. I didn't, but I could have.

Looking back on that experience, it was a wonderful benefit to have. There is no question that I overused the system. No question that I abused it. I didn't deliberately do it. I didn't set out maliciously like Phil Gramm would suggest, but it happened. When we got from under the Hughes circumstance and suddenly were faced with a more realistic circumstance, then we started to make some intelligent decisions as to whether we really needed to call the doctor, or whether we could do something ourselves. Catastrophic events like the birth of a child with major birth defects, mental retardation, that is going to cost $50,000 a year for the rest of that child's life, shouldn't ruin a family's life the way it does now. But a government-supported single-payer system that provides first-dollar coverage for aches and pains, insurance will bankrupt the Nation.

I will close with this analogy. Homeowners insurance. Every homeowner in America has homeowners insurance. There is no government mandate that you must have homeowners insurance. The market forces it and people are smart enough to buy it.

If my home burns down, my homeowners insurance will not only replace the home, it will replace the dishes on the shelves, the carpet on the floors, the pictures on the walls, and give me some spending money for new clothes, everything in the home, 100 percent coverage for a catastrophic event. The premium for that homeowners insurance is relatively low considering the benefit that I would get. But the premium does not cover the cost of mowing the lawn, does not cover the cost of painting the front door, does not cover the cost of replacing a light bulb. But somehow we are saying that our health insurance isn't universal coverage if it doesn't take care of everything that goes wrong with us.

If you could somehow wave a magic wand and say that the single-payer, universal coverage, government-controlled insurance that is going to take care of everybody has a level below which it will never go, as I say, with the constitutional amendment, I would say, then, I will talk to you about it. I won't be ideological; I won't plant my feet in cement and say never, never. But if we can't break the paradigm of the American that says my insurance has to cover the cost of mowing the lawn or somehow it isn't universal coverage, then I say we can't ever let the government do this.

DR. REINHARDT. I couldn't disagree with you, because I wrote somewhat the same speech in a paper at a Princeton conference reacting to the Clinton plan. There, I made the point there are two dimensions to universality. One is how many people are covered, and the second is how many services are covered.

For some reason, we have gone from covering every service in the package and phasing in very slowly the people. I would have gone the other way. The model is the Medicare program, which pays for, on average, less than half of the health care of the elderly.

It is not a generous program. If you want to see something close to first-dollar coverage, look at what the *Wall Street Journal* gives its employees. It is astounding that a conservative newspaper like that would actually give its employees something that is beyond belief and contradicts their own editorials.

SENATOR BENNETT. Not necessarily, because, again, having been an employer, you want to acquire a certain kind of employee and you do things to acquire the employee, and you realize that if you are smart, very quickly that the employee is not attracted to you solely by salary.

Sometimes you paint everything green or blue, or whatever, because the employee is more likely to work for you if there are pleasant surroundings. I put a lot of money into landscaping and a lot of people say, why are you spending this much money out of this piece of property? I say, because it holds down my turnover rate. Employees eat their lunch under the trees and they are less likely to go work for somebody else.

This isn't my ego speaking; this is an intelligent employee decision. The *Wall Street Journal* may have decided that in order to get the kinds of employees they want, this is the kind of benefit we are going to give them, and it is a competitive edge on their part. I know that was a deliberate decision on the part of the Hughes organization; this is the kind of people we want and this is what we are going to do to hang on to them. It is an employee cost, and an employer is free to make the decision.

DR. REINHARDT. It would be good if this were a taxable item to the employee like all other forms of compensation. That is a problem economists have with this scheme. We believe all employer-provided fringes are shifted into wages. This means that a corporate executive effectively gets dental and vision care at half the price, because for every dollar of insurance he or she loses, only 50 cents comes out of income, while the janitor pays 85 cents of income because the marginal tax rate is lower.

Why not add this to taxable income, that way all compensation is taxable. Then you would get an economically correct choice. You tell the employees, would you like to have your wages in this blue box cash, or would you like it in the green box fringes, but it will be taxable income to you one way or the other.

SENATOR BENNETT. I ran a cafeteria plan for my employees and said you get so many benefit dollars, flex bucks and you decide, you want them spent for health care, for your 401-K plan, for day care—we are

willing to spend $300 a month for you and you get to decide. You would be surprised how many of them did not take health care.

But why does it have to be taxable? It never has been. Why not say, look, I am paying you $20,000 a year in taxable dollars and $10,000 a year, right now, in nontaxable dollars, which is roughly what it runs. It is about a third of your employee costs, which are nontaxable dollars, that I am spending on you.

Why do they have to be taxable? Why can't you say to the employee that you get to choose how those tax-free dollars are spent? If you want to take $300 a month out of that and spend it on the health-care plan, blessings on you. The Federal Government is not taxing you on it now because I am spending it; it won't tax you because you spend it.

I don't see why we have to say that it always has to be taxed. It isn't taxed now and the economy survives.

DR. REINHARDT. What you then do as the Congress is, you are saying that you favor some sort of consumption over others.

Maybe we ought to visit on that again.

SENATOR BENNETT. I will come to Princeton and talk to you. I apologize for having to leave.

REPRESENTATIVE HAMILTON. I wanted to talk about the growth in health-care costs. Is the market solving that problem of growth in health-care costs?

We have seen a lot of articles suggesting that in the last year or two, this rapid increase has come down.

DR. REINHARDT. It has, but it also did in 1984 to 1985. Every once in while you get breathing spells. From 1984 to 1985, it seemed like health-care costs were under control. Secretary Heckler, I think, went on TV and announced that we have slain the monster, and some of us said that you need a longer run to be sure.

At the moment, we are in single digit increases in premiums, although they still proceed often at twice the rate of general price inflation. So you always have to look at this in real dollar terms.

REPRESENTATIVE HAMILTON. What is your judgment? Are we going to repeat the 1984 to 1985 experience and see this thing take off again?

DR. REINHARDT. I wrote an article and predicted that it will take off. I am cautious because managed competition could for awhile wring out a awful lost of prices and excess capacity out of the system. This may be a longer run.

I personally am convinced that from 1996 on, we will again see fairly stiff price increases relative to general consumer prices, because there is only so much fat in the system and that fat is now being wrung out by making specialist unemployed, cutting their fees, closing hospitals. But once that fat is out, ultimately technology will drive the system.

REPRESENTATIVE HAMILTON. Why is universal coverage desirable? Obviously, it is desirable in terms of people; everybody has medical care.

But from a systemic point of view, why is universal coverage important; or is it?

DR. REINHARDT. I think ultimately it is a political and value call. You could certainly run with a society that has, say, 90 percent of the people covered.

REPRESENTATIVE HAMILTON. What percentage are covered today?

DR. REINHARDT. Eighty-three. If you went to 90 percent, then you would have, say, 20 million uninsured people. Most of them would probably be fairly young.

In an editorial that was in yesterday's *New York Times*, I said that it really is a society that has features of a Russian roulette. Imagine having a revolver with 10 chambers, one bullet. Would you want to play with this thing?

And what I would tell the middle class, you are then living in a country where at any time 20 million people are in the hole, not insured. If they get sick, they will get care, but maybe late, and they will be broke. Whatever their savings was, it will be gone.

But the people near the hole are not secure either. They may fall into it. You may lose your job, lose your insurance; so you live with insecurities and that is a political question.

One of the handouts that I gave out reads that 50 percent of America's corporate executives in a recent survey said that they don't want to give the uninsured insurance. I say that is a respectable view, because you are rich and you will be paying for that, and you tell us that you don't want to pay for that. I respect that. You could live with a society that has that. So I don't think it is as much an economic view as an ideological view.

REPRESENTATIVE HAMILTON. How do you get to universal coverage? What are the options. You talked about employer mandate, individual mandates, a single-payer system; any other options?

DR. REINHARDT. Ultimately, to get universal coverage, you have to have compulsory coverage for at least a solidly catastrophic.

REPRESENTATIVE HAMILTON. Are there any options other than the three I mentioned, individual employer, single-payer?

DR. REINHARDT. Not really. That is it.

REPRESENTATIVE HAMILTON. Now, you are not too strong on the employer mandates. Why not?

DR. REINHARDT. Well, actually, if the employer mandate is played out the way the social insurance systems do it in Europe, where you essentially say everyone must be insured, and to make it easy we collect that at the nexus of the payroll for anyone connected to the workplace, I don't call that an employer mandate, because the only thing the employer is mandated to do is put a little code in the computer that siphons off the money from the paycheck and puts it in the insurance pot. That kind of employer mandate I am not opposed to.

But the employer mandates that we have, which essentially puts a premium that is a head tax on the employee, put a heavy burden on a low-wage industry. Then you say, well, we can fix it by giving subsidies to small business firms with low-wage employees, but now you have brought the size of the firm into the game and you get all kinds of gaming. If you make under the magic number, then the 99th employee was the last cheap one you had and you get all these notches. So most economists would argue let's not put the size of the firm in as a legislative parameter, otherwise, you get bad economic decisions.

REPRESENTATIVE HAMILTON. So you basically agree with the small business people who say that if you put an employer mandate on us, we are going to let people go from the payroll, we can't afford it?

DR. REINHARDT. I don't quite agree with them. They usually come and I sympathize. The usual image is, I run a Burger King or a restaurant and my employees get $15,000 dollars a year. Somebody tells me I have to buy a $5,000 product and give it to them on top of this, how can I compete. They always think the other hamburger stand won't have that problem.

But if every hamburger stand in New Jersey had to pay $5,000 more, what you would find initially is that the price of hamburger would go up somewhat and people would eat them anyhow. Because the minimum wage was raised, it did not displace these workers.

The problem comes when you make that a premium that hits a low-wage worker at $5,000 and an engineer at $5,000, rather than "X" percent of the payroll the way the Europeans do it, where a 10 percent hit on the payroll wouldn't be nearly as bad as laying $5,000 on top of someone who makes only $15,000.

The President's employer mandate had this premium, but for small low wage they converted it more and more into the European-style payroll tax, but in a very complicated way that requires you to have benefit managers and lawyers.

In Germany, companies don't have huge benefit departments. They don't need it. It is so simple. Every American company has a huge employee benefit department that hires high-priced consultants who tell them about benefits.

REPRESENTATIVE HAMILTON. How would you get to universal coverage if you were designing the system?

DR. REINHARDT. The proposal I would have and I did last year put in, is to say, don't touch the whole system; it touches too many people.

Simply say that whoever is not insured will fall into a federal fail-safe system. You have to put on your income tax form evidence that you are privately insured, certainly not with the first dollar, but a good catastrophic policy, and if you do not have that evidence, you must pay an extra surcharge into a federal fail-safe pool of your adjustable gross income if you don't have private insurance. That goes into a federal pot.

There would be a tobacco tax going into that and other such taxes, and I would say let us convert to taxable income the fringe benefits of

people making $35,000 or more, phase that in. If you make $50,000, maybe 30 percent of your fringes will be added to your W-2 form so that a corporate executive would buy dental care with his or her own money, not tax money. That would give you $30 or $40 billion and those pots would be enough to have folded the uninsured into the federal employee benefit program, or through them give them a policy or Medicare. It could have been done. I think we could have had universal coverage that way last year. Not now.

REPRESENTATIVE HAMILTON. If you look at the plans that are floating around here, Jim Cooper's plan, the Gramm plan, which do not have the employer mandate, is it possible under their plans to get to universal coverage?

DR. REINHARDT. I don't think so.

REPRESENTATIVE HAMILTON. You have to have an element of compulsion, you said a moment ago.

DR. REINHARDT. Yes. The reason I think you have to have it is that they reformed the insurance industry by saying that there has to be community rates. The question is, what do you mean by a community? They haven't even begun to think about this, and I think we are running out of time to think about it. Is Westchester County and Harlem one community or are they two?

Second, if you exclude preexisting conditions those two mandates on the insurance industry allow anyone to walk in and say, look at me, I am going to cost you $100,000, here is my $3,000, insure me. That will drive up the community-rated premiums and many young people—at age 25 everyone is immortal—they will argue, I am going to luck it out. If I hit a tree, there is the emergency room and if I don't, I save this money. So I think you will create a lot of uninsured.

REPRESENTATIVE HAMILTON. One of the areas where you get a lot of figures thrown around is this area of savings that you get from the Medicare program, and the President thinks he can get $118 billion worth of savings out of Medicare. Now, as you know, the older people are very nervous about that, very skeptical about it, fearful about it. Is the President's figure of $118 billion, or whatever the figure is, is that a soundly based figure, do you think? Can you get that much savings out of Medicare?

DR. REINHARDT. Actually, I think, if it were skillfully done, you could. First of all, that is off a fairly steep trend line. I forget the numbers, but it is sometimes better to look at not the savings but what the President proposes to spend, and I think when I looked at this, it was a sizable amount of money in the President's budget for Medicare in the future. So I think that is much less alarming than looking at the savings.

But I didn't, I think, bring my irreverent Christmas card—I had a display from an Urban Institute study that shows spending per elderly, age, sex, adjusted for doctors in various cities in the United States, and you will find that according to the study in Miami, we paid doctors, that is Part B Medicare, $1,800 per elderly, and in Minnesota, only

$822. That difference is larger than the difference between Canadian per capita spending and America; it is almost the same as England and America.

In the Christmas card, of course, I called Minnesota "brutal rationing" to tweak the nose of my friend Senator Durenberger. Minnesota has some of the finest health care in the world.

So you should ask when doctors come before you, explain the chart to us, what is going on, age, sex and price differentials have been taken out, what are Miami doctors doing with patients that Minnesota doctors are not doing. Even New York, which is usually so pricey, spends only $954 per elderly. If you want to go after Medicare spending, perhaps you ought to use a database like this and go after Miami. If you took 20 percent——

REPRESENTATIVE HAMILTON. Why is it that high?

DR. REINHARDT. We do not know. That is why in my other guise, I never lobby, but I do lobby for health services research, because that is what gives you such numbers that allow you to ask what is actually going on in Miami. We did get the Agency of Policy Research funded in order to look at clinical outcome studies to see if what they do is justified and what works.

REPRESENTATIVE HAMILTON. If we look at the sources of money, financing up here, you are looking at the savings we are talking about out of Medicare, Medicaid, we are talking about a tobacco tax, an employer mandate—are there other sources from which we could get revenue for health care that you think would be good?

DR. REINHARDT. The one source where you would literally get the entire American Economic Association on your side would be to begin to tax employer-provided health insurance. We consider that tax preference highly inequitable but also inefficient. And I couldn't get a response to the Senator. It is the inefficiency of it that troubles us. The notion is that I am subsidizing the purchase of first-dollar health insurance coverage, which the Senator thought was a problem. Well, that is why the *Wall Street Journal* has it. The reason they give their employees this lush policy is that it is out of pretax dollars.

I sat on the board of a company and it was proposed to put in dental care, and the natural juices began to flow and I protested. I said dental care is not an insurable item, you should pay that out of your own pocket. I was told by these executives, but we are getting this for half price; how can you resist it? And I voted for it. That is how it goes in every board meeting.

There is no reason why the *Wall Street Journal* should give its people dental care other than they can get it for half price.

REPRESENTATIVE HAMILTON. I would like you to comment a little bit about the benefit package. How much should you put into a benefit package and what kind of things should you exclude? Should you cover mental health?

DR. REINHARDT. This is a thorny issue driven by two parameters. On the one hand, there are definite health needs—

REPRESENTATIVE HAMILTON. I am talking about the benefit package.

DR. REINHARDT. On the one hand, there are definite medical needs that as conscientious legislators, you would like to include, but on the other hand, you are besieged by people who derive income from delivering these services. And this happened, I think, in the House Ways and Means just yesterday, that the benefits package was—

REPRESENTATIVE HAMILTON. It is awfully hard to draw a line.

DR. REINHARDT. It is extremely difficult, and therefore I think this will always be a contentious and political issue call. My approach would be start lean. You can always add or give people riders where they can get additional benefits, but start lean rather than too generous, because when it is too generous, you can't afford it.

REPRESENTATIVE HAMILTON. If you have a lean package, you will have a lot of Americans who are going to buy more.

DR. REINHARDT. Yes.

REPRESENTATIVE HAMILTON. Then you end up with a two-tier system; in other words, the well-to-do people are always going to put themselves in a position where their families are well covered for almost all contingencies.

DR. REINHARDT. Yes.

REPRESENTATIVE HAMILTON. If you have a benefit package that is fairly lean, that benefit package is the only package available for people on a lower-wage scale, so you end up with a two-tier system.

DR. REINHARDT. Absolutely. I think it is a dream to think that we won't have a three-tier system, because the elite will always have health care of a sort that clinicians wouldn't even defend. There will be a fairly lean regime for public-financed patients, and eventually the elderly will have to come to terms with that as well. There will be whatever the middle class wants to afford, and there will be boutique medicine for the elite.

REPRESENTATIVE HAMILTON. You mentioned some of the problems with the community rating system. Can you go into that a little more? What does it mean? What are the problems with it?

DR. REINHARDT. First of all, technically how would you get a community rate.

REPRESENTATIVE HAMILTON. What is a community?

DR. REINHARDT. You have to define what is a community, which is a geographic concept, or it could be any definition, it could be that all economics professors are a community, but you have to define that. Once you have defined what the denominator is, you take all the health spending that they will incur, divide one by the other and you get the actuarial community rate for that community. Then you say that everyone who wants to join that pool must pay that rate.

You could have a modified community rate where you say you can do it by age group, so you stratify it by age so that young people don't subsidize old people. Within an age cohort, very sick people will be subsidized by very healthy people if they join that pool. If the joining is voluntary, then you will inevitably get a flight from insurance, because young or healthy people will say that they are not going to pay this. That makes the pool sicker, makes the rate go up and drives out even more—the way we had the flight from the city with the tax code, where each time people left, the tax base shrank; therefore, the rates went up and more people left.

REPRESENTATIVE HAMILTON. If you don't have mandates——

DR. REINHARDT. If you don't have compulsion.

REPRESENTATIVE HAMILTON. If you don't have compulsion, you go to a community-rated system of some kind?

DR. REINHARDT. You could leave it as it is, where it is actuarial fairly priced. That, however, means chronically ill people don't get insurance unless you subsidize them separately.

REPRESENTATIVE HAMILTON. What is New York's experience?

DR. REINHARDT. Flight from insurance of young people.

REPRESENTATIVE HAMILTON. When was that put in?

DR. REINHARDT. Two years ago. It is basically community rated on geographic ... I am not sure if it is all New York, but it is community rated. It was basically to help Blue Cross, frankly, and as I don't think there have been in-depth studies——

REPRESENTATIVE HAMILTON. So the experience in New York has not been good?

DR. REINHARDT. It is disquieting, but still going on.

REPRESENTATIVE HAMILTON. Senator, do you want to go ahead?

SENATOR BENNETT. You are on the same subject as when I had to leave, because I said that somehow universal coverage has to be catastrophic, and we have the rest of the package for the rest of the problem to be addressed. My reaction to this is to define the basic benefit package in terms of dollars rather than services, and let the market work.

Back to what I was saying when I had to leave. In a cafeteria plan, you have so many benefit dollars, you spend them the way you want and you take the consequences, and we have employees who say, I don't want any health-care coverage, I want all those benefit dollars to go for day care.

We were talking earlier, Mr. Chairman, about what is lost with the money spent on health care, what is it not spent on. In these cases, these women said that they wanted money spent on day care. Suppose we say all right, the basic benefit package is going to be in terms of dollars. Picking up the discussion, you somehow complained about these dollars being marketable and wanted to make them taxable. Suppose we say all right, we will leave the present system in place, where

an employer can offer benefit dollars that are nontaxable to the employee and still deductible to the employer, a payroll cost.

I would argue that a payroll cost is a payroll cost. If I am a foolish employer who wants to put money into fountains in my workplace, I deduct that and I take the risk as to whether or not that produces a better work product in the workplace.

You want to say, okay, we will put a limit on the amount of benefit dollars that can be deductible to employees and deductible to the employer and tax free to the employee. We could debate that. But what is wrong with the concept of saying that the employee has "X" number of tax fee dollars to spend however he or she wants on health care and let each individual construct his own basic benefits package out of a combination of those dollars and his or her own after-tax dollars.

A hypochondriac buys a policy that covers everything. The person who is convinced that all doctors are witch doctors and the only people who can be trusted are chiropractors can use those benefit dollars to call on a chiropractor. The person who believes in holistic medicine and crushed butterfly wings, can live off butterfly wings, and the government doesn't have to make any of those decisions. What is wrong with that?

DR. REINHARDT. Supposing you had an employee with diabetes and a heart condition and you have this package that is averaged, who would sell such a person an insurance policy knowing how expensive they are going to be? Take someone with AIDS, for that matter. At the amount that the employer might put in there, maybe $4,000 can be spent on either health care or anything else you want, how would you guarantee that your employee with AIDS or with diabetes would in fact get a policy for that?

SENATOR BENNETT. Presumably, he or she would have gotten a policy prior to getting AIDS. Presumably, everybody gets their health coverage at the time when they are healthy and it carries with them when they are unhealthy. If the individual controls the policy rather than the employer, the previous condition circumstance goes away.

When somebody goes to work healthy and then is discovered to have diabetes or a heart problem or AIDS, they are already in the pool because they have bought the thing that says, if I get these, then if it becomes truly catastrophic, then they go up into the catastrophic level and get taken care of, so the pool doesn't have to concern itself with the truly catastrophic circumstances.

DR. REINHARDT. Suppose I want to switch jobs or move to another state.

SENATOR BENNETT. Under my system, you have bought the policy, you own the policy, you take the policy with you. It has no connection with your employer whatsoever. The employer gives you the tax-free dollars and the salary dollars and you spend them however you want.

DR. REINHARDT. That would work if you then had a lifetime, basically, guarantee the company could not cancel your policy essentially.

SENATOR BENNETT. That is right.

DR. REINHARDT. But what if you were chronically ill from the start, you come out of college sick or are likely to get sick, and with genetic testing we can tag people like we have never been able to do before?

SENATOR BENNETT. That crosses the border into the catastrophic area, which I was talking about earlier. I would be willing to talk to you about universal coverage for every person in the country on catastrophic so that somebody who crosses the border into a catastrophic circumstance and is overwhelmed, gets taken care of.

I said to the head of a large insurance company, what if you split the system and dropped off everything but catastrophic? They said about 10 percent of our current premiums could cover everybody in the country for catastrophic, which shows the enormous waste in our present system processing paper for flu shots, or my analogy, mowing the lawn. Why should I file an insurance claim and have three clerks shuffle the paper through the system and write a check and send me back for mowing the lawn?

A flu shot is a $15 office visit and it costs $30 because of the paperwork.

DR. REINHARDT. Why do the *Wall Street Journal* employees put in a claim for flu shoots? Because you give them this tax preference and this commodity is so cheap—first-dollar coverage—that they buy it and thereby most corporate employees are the ones that have the first-dollar coverage.

SENATOR BENNETT. But it is not so cheap anymore. More and more employers are moving away from first-dollar coverage. I came out of my Howard Hughes experience; it was wonderful as an employee, and when I was putting the health-care system in the business as the CEO, I said let's do what we did at Hughes. It was great, employees loved it.

I had wiser heads say to me, you don't want to do that. And we didn't and we put in a system currently self-insured, where we say to the employees every month, this is what it is costing. And we are deducting so much out of your paycheck if you have elected health insurance—under the cafeteria plan, they can opt out entirely—if you elected health insurance, this is what our experience was this month.

If this experience repeats next month, everybody's premium is going to go up. We say this is our experience the next month; you held it down, your premiums go down. Our employees understand. That is a decision I made as an employer. I am getting the results I want out of my employees.

The *Wall Street Journal* has made their decision as an employer. Presumably, they are getting what they want in terms of retaining employees. The free market works that way. The management ought to be allowed to make a dumb decision if they want. That is one of your privileges in America.

DR. REINHARDT. I would be the first to shout that from a steeple.

SENATOR BENNETT. The government makes the decisions in the Clinton plan.

DR. REINHARDT. We could argue that the Clinton plan probably wouldn't touch them very much. I would say that it would be fine to make these managerial decisions if they were made on a level playing field without a tax preference. Then I could go for that. The tax preference troubles every economist alive, because it is not only inequitable but inefficient.

Get my ultra-conservative colleague, Martin Feldstein, and discuss it with him. He won't be as calm as I am about it because he has made a religion out of it. Get Allen Enthoven(spelling ???), get any economist, and he will go ballistic on this issue.

REPRESENTATIVE HAMILTON. We will bring that up with him.

My guess is that in my constituency, which is a fairly conservative constituency, 80, 90 percent of the people favor price controls. Why are these doctors charging me so much money? Why do I have to pay so much for 2 days in the hospital? These prescription drugs are driving me nuts. Why don't you fellows in the Congress slap price controls on these people and make them behave themselves?

I hear that all the time, and I think the national polls support what I have said. Ordinary Americans think the way to solve this problem is price controls.

SENATOR BENNETT. Seventy-eight percent.

REPRESENTATIVE HAMILTON. What do you say to that?

DR. REINHARDT. This is somewhat amusing, and I have to laugh—recently, I was in Nashville with some truly rich Princeton alumni and they were in one conversation running down the government, but also complaining what pharmaceuticals cost them. I happen to think that relative to cognac, most pharmaceutical products are cheap. But they were complaining about this.

I personally think that before you go out——

REPRESENTATIVE HAMILTON. We are not going to do it, obviously. I want to be able to respond to that.

DR. REINHARDT. I have lived here for 30 years and the longer I live in the United States the more I now know I will never understand this country. I recently had the privilege to testify before Senator Rockefeller on the Veterans Administration, and I asked an impertinent question: Why do we have a VA? Why do so many conservative Senators go to the mat to defend purely socialized medicine that even the Russians don't run anymore? Canada doesn't have socialized medicine. Why are American veterans so fond of socialized medicine?

I don't know the answer. I am trying to study it. I actually brought and I gave Dr. Ruggles a paper I had submitted to the Wall Street Journal last year, because I didn't think price controls were necessary on doctors.

You could have done something and we should have done that with Medicare in the hospitals the following: The government has developed a relative value scale for doctors and for hospitals. For hospitals, we call it DRG, where you basically could express for 500 cases the fee of each, relative to a base fee that is given a unit of 1. For physicians, the unit is a routine follow-up visit that has a value of 1 and Medicare now pays $35 for that. And then another procedure has a value of 2; Medicare would pay $70. So you can explain the entire fee schedule with one number.

I propose that Congress pass a law that every doctor must use for pricing that relative value scale, but they can put their own money value on the base unit, which then defines the entire schedule, and post it so that the newspapers can print it, that there would be an 800 number I could dial that says Dr. Jones charges a $5.00 conversion factor. Then I know every fee would be that much higher and advertise those.

Also, for hospitals, you would have hospitals post the base price instead of having government set these fees, which is what we now do. Each hospital would say, for the base unit, which is an appendectomy, we charge $100 and all the other hospital charges would be known.

REPRESENTATIVE HAMILTON. Let me go to my question.

What do I say to the person that comes to me and says set the prices? Why is that not a good thing to do?

DR. REINHARDT. It is very difficult to do this right. To not hit it either too low or too high is very, very difficult.

REPRESENTATIVE HAMILTON. What happens if you don't set it correctly?

DR. REINHARDT. If you set it too low, you might get shortages, unless you have it for absolutely everyone, doctors not accepting patients with price control fees. Most countries use that of course.

REPRESENTATIVE HAMILTON. Price controls?

DR. REINHARDT. Canada does, Germany, France, Japan does. Every country I know does. What typically happens is, if you set those prices too low, they just do more or unbundle what they do. This is what we find in Germany, Japan——

REPRESENTATIVE HAMILTON. Massive bureaucracy?

DR. REINHARDT. You do get into a bureaucracy, which I think, with my system, you could avoid and then you could negotiate as a HMO with doctors around one number. To some extent, I think that is something we should have tried. You could still put a trigger on.

REPRESENTATIVE HAMILTON. Do you think doctors, hospitals or pharmaceutical companies today are ripping the public off?

DR. REINHARDT. No. I don't use that language.

REPRESENTATIVE HAMILTON. I am using the language my constituents use. I am not arguing it. I hear it all the time: They are ripping me off, Congressman.

DR. REINHARDT. I would disagree. They are charging what they can get away with. Somebody is paying it and why is that ripping off? Do I

rip off? Everyone tries in our economy to get the best deal they can get, and why should they voluntarily hold back? The lawyers are not doing that, architects are not.

REPRESENTATIVE HAMILTON. Professors are not.

DR. REINHARDT. We do. We are underpaid.

SENATOR BENNETT. Depends on the university.

DR. REINHARDT. That is the point. When we are consulted, we are not diffident. I think it is not the right approach——

REPRESENTATIVE HAMILTON. Let me ask you one other thing. I wanted to ask you about this trigger business, how you feel about that. The approach that I think is being taken in the Senate, in some of the plans and certainly in the House as well, is that you try to get as close as you can to universal coverage. You may hit 90 percent, but you don't get there all the way and then you have a trigger. You have the soft trigger and the hard trigger.

How do you respond to the whole concept of trigger?

DR. REINHARDT. Basically, we have three, we have those plans, Senator Gramm's, that basically have no trigger and then you have the other extreme, the very definite timetable that the President proposes, and in between you have soft and hard triggers.

I would say, if that is the best you can get, take it. Basically, I call a soft trigger a "Scarlett O'Hara technique." Wasn't there a last line, "I'll worry about it tomorrow; tomorrow is another day." It basically says that we have this goal, and it is certainly worth keeping an eye on that goal rather than saying we have reform and we won't look at it for 20 years.

Here you have reform, and we will monitor what it does and if it doesn't do it, some earlier Congress said we should look at this, but every Congress can do what it likes, so therefore a soft trigger is just that. A hard trigger is also a soft trigger. I view every hard trigger as a soft trigger because Congress can always undo it.

They have been known to repeal laws before. They require more action, but a hard trigger doesn't bind a future Congress to maintain it, I don't think.

REPRESENTATIVE HAMILTON. Do you think we can contain costs with managed competition? And if we can, what do you mean by managed competition?

DR. REINHARDT. By managed competition, I understand the pitting against one another of capitated managed care systems. Managed care, means somebody monitors what doctors and hospitals do and also bargains over prices with them. That is managed care. Managed competition is pitting these systems that do that against one another in the competition over a premium for that.

I think such a system, if played out properly can, at least, for awhile, dampen costs, and it seems to me that we are seeing that. You would have to be bigoted not to say that at the moment these managed care systems seem to be doing that.

My colleague Joseph Newhouse has done literature on HMOs and found that while their costs may be lower than that of the fee-for-service system, in the past the growth rates from year to year have been the same. He attributes that to, new technology that comes gets used. I believe there is a real sleeper that managed competition is inimical to technical innovation and that has to do with the fact that if you have large systems like the Columbia HDA system, they can go to a pharmaceutical company and say, we want your product, your antibiotic, but at a discount off full cost. The company will say, but we have to recover our R&D, and they will say, we understand this, but we are competing against some other system. Private competitors cannot worry about other people's R&D. This is one of those speeches I gave health reform through bounty hunting. I think at some point the Congress has to keep a eye on what managed competition will do to R&D, device manufacturing, pharmaceutical and biotechnology.

REPRESENTATIVE HAMILTON. But, in general, you feel that the managed competition concept would be effective in containing health-care costs?

DR. REINHARDT. In containing costs, it has a side effect that you may or may not like. There may be underservicing of patients. There will be rationing. The whole idea of managed competition is to ration. Economists are not opposed to rationing.

You will be shocked to hear that any economist would have to tell you that any system that doesn't ration is inefficient. That is what we teach. We don't apply that when we are personally sick, but nevertheless that is what we teach. So, therefore, the rationing doesn't disturb us, and if it goes too far, how do we catch it?

There has to be monitoring; there has to be a data system that follows this. You have to have information on patient satisfaction that is objective. Somebody other than the HMO has to produce that. You want something on clinical outcomes I think, but not to give to people, because I think they will be confused by it, but savvy buyers who can say this doctor is really not good or this product doesn't work. If you had this, I think it is worth a try, and we are trying it.

SENATOR BENNETT. I just want to compliment you and thank you for your presentation. It has been very useful.

If I could close with my speech, this is enormously complex. The stakes are enormously high. Life being what it is, there is a 100 percent probability that if we try to do it all, in a single bill, in a single Congress, we will get it wrong and probably make it worse. This is, I hope, not a partisan note, but I love what Bill Saffire said in this morning's *New York Times*.

> Bill Clinton deserves credit for getting us started, and Bob Dole deserves credit for stopping us at the right place. I think we should stop there, see what happens, discover.

There are all kinds of things wrong. Revisit this in the next Congress, make some changes based on the data that comes in, revisit it in the next Congress, make the changes. Again, in the context from which I come, if I were the CEO of a corporation and someone came to me and

said that we have a division in our corporation that is in real trouble; it is not delivering what it needs to deliver to the customer, the costs are out of control, the bureaucracy stifling—and by the way, it is losing $800 billion a year—I would say let's fix the division very carefully. If it is doing $800 billion a year, let's not call IRA Magaziner and have him give us one of his 60-day wonders. Let's do this very carefully.

DR. REINHARDT. You may ask why are people pushing for doing this all at once. My plan is a far more conservative plan; it leaves the private sector alone. There is a view that many policy "wonks" have, and I am not sure if it is true, but the religion is that Congress makes major health policy every 20 or 30 years, so we will do it again in 2015. That is why people say, let's load up this train, because the next train takes 30 years.

If one had some assurance that the Congress would consider this like the budget—an annual review of the health care. And maybe you need some commission like the Physician Payment Review Commission, that the Congress says we will do this; see how that works and then we will fix it according to the wishes of the people, I think a lot of people would sleep much easier with Senator Dole's approach.

The big fear is that their train came, that is what we loaded on it and we will have to wait another 30 years. I hope Senator Dole could also assure us that he will revisit it next year.

SENATOR BENNETT. I can't speak for Senator Dole.

DR. REINHARDT. That is very reassuring.

REPRESENTATIVE HAMILTON. We stand adjourned.

[Whereupon, at 11:40 a.m., the Committee adjourned, subject to the call of the Chair.]

SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF UWE E. REINHARDT

Every so often these days, word leaks from the White House that the Administration will impose a price freeze upon the health sector or, alternatively, extend the Medicare fee schedules for hospitals and doctors to the entire health sector. Alas, the first option would be difficult to police and probably lead to a bureaucratic nightmare. The second option would be easy to implement, but it would subject many a hospital and physician to a severe financial shock, because Medicare rates are much lower than the fees providers charge private patients. Is there a third alternative?

There may be, if one is willing to gamble that mere *price transparency* would serve to constraint health-care prices. Thus, one might impose upon the entire health sector the *relative value scales* developed by the Medicare program during the 1 980s, but allow doctors and hospitals to set, for non-Medicare patients, their own monetary conversion factors for these schedules, at least in a transition towards more uniform, negotiated fee schedules.

A *relative value scale* expresses the fees of all procedures in a fee schedule in terms of relative value points. Suppose one selected a routine office visit as the base procedure and assigned it a point value of 1. Then an echocardiogram might have a point value of 6, a normal appendectomy a value of 12 and a gall bladder operation a value of 20. These relative value points would reflect estimated differences in the cost of performing the procedures. Now, if all physicians used a common *relative value scale* and Dr. Jones charged, say, $50 for a routine office visit, then he or she would charge $300 for an echocardiogram, $600 for an appendectomy and $1,000 for a gall bladder operation. If Dr. Chen charged only $40 for a routine office visit (i.e., 20 percent less than Dr. Jones), then all of his or her fees would be 20 percent lower than Dr. Jones'. In short, one could easily compare the fees charged by different physicians in the community by a single number: their fee for the base procedure, in our case the routine office visit. That fee would be called the physician's "conversion factor."

Under the proposal recommended here, physicians would be mandated to use the *relative value scale* that the Medicare program has developed for some 7,000 procedures performed by physicians. But physicians would be allowed to apply to that relative value scale their own monetary conversion factors for privately insured or self-paying patients. That factor would apply to all private patients; extra billing on a patient-by-patient basis—i.e., price discrimination—would not be permitted. If physicians were made to announce their conversion factor at the beginning of each year, then these factors could be published in the local newspapers and routinely made available to patients via an 800 telephone number to facilitate price comparisons without having to pry loose that price information directly from one's doctor.

A similar mandate could be imposed upon hospitals, with the *relative value scale* based upon the federal case payments, although only if cost sharing by patients were negligible or confined to a simple deductible. The all inclusive federal fee per medical case is in effect an average for relatively simple and complicated cases within the same diagnostic category. If patients were forced to pay, say, 20 percent of each hospital bill out of pocket, then patients with a relatively simple case within a diagnostic category would be forced to subsidize, through their share of the *average* fee for that case category, patients with

relatively complicated cases. That might cause considerable social tension. For that reason, an extension of the idea proposed here to the hospital sector would require that any cost sharing by patients take the form of a flat sum per admission, where that flat sum would vary directly with the hospital's announced conversion factor.

The approach recommended here could be implemented swiftly, even this year. All the hardware and software for the federal schedules are fully developed and are well known to the providers of health care. The policy would not constitute rate regulation, because it leaves the conversion factors for private patients fully to the individual providers' discretion. The policy merely mandates doctors and hospitals to reveal their prices in a manner patients and their insurance carriers can easily understand. Surely neither doctors nor hospitals can legitimately object to that transparency. In fact, the American Society of Internal Medicine has already endorsed this approach.

This high price-transparency alone probably would serve to drive health-care prices towards greater uniformity and acceptable levels, even without explicit rate regulation. It would be fairly easy to simulate, for example, what income levels the typical physician could achieve at various levels of the conversion factor and to publish those estimates along with the conversion factors themselves. Patients could then decide for themselves whether their doctors really "needs" the higher income implied in a high conversion factor and whether they wish to underwrite that need with their own money. Furthermore, private employers who provide their employees with health insurance could then insist that employees confine their choices to physicians with stipulated maximum conversion factor of $X or less, or pay 100 percent of the portion of a physician's fee that exceeds an implied conversion factor of $X (and likewise for hospitals). Chances are that such a stricture would quickly drive the fees of higher-priced providers down towards the stipulated maxima.

The policy would have one major additional advantage: it would greatly facilitate the spread of electronic billing on the basis of common claims forms. While electronic billing has by now become the dominant form of reimbursement under the Medicare program, it is still in its infancy in the private insurance sector, precisely because fees have been so chaotic there. If all doctors used the same list of procedures and all hospitals did likewise, many billions of dollars now spent on paper pushing could be saved, a wasteful effort that makes our current health system probably the most administratively cumbersome system in the world. The time has come to cut that waste.

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